Washington State Health Care Authority

Surgery Prior Authorization through Qualis Health

Frequently Asked Questions

1. Q: Review for medical necessity of surgical procedures through Qualis Health and prior approval from Washington State Medicaid is not required for clients who belong to a managed care plan. Are there other situations where this is true?

   A: Prior authorization is not required when another insurance carrier is going to be financially responsible for payment. So do not request authorization for a client who has:

   - Medicaid Managed Care, or
   - Another insurance as primary (Third Party Liability or TPL), or
   - Medicare as the Primary Insurance, or
   - No current eligibility, or
   - Unmet spend-down, or
   - Detox only coverage, or
   - Coverage under the ERSO (Emergency Related Services Only), a non-citizen program.* See Question 9 for more information.

     * Submit requests to the Washington State Medicaid.

2. Q: Do all surgeries require prior authorization?

   A: No, the list of surgical procedure codes requiring authorization can be found at: http://hrsa.dshs.wa.gov/authorization/.

3. Q: If Washington State Medicaid is a secondary insurance, do providers still need to request the prior authorization?

   A: Prior authorization for surgeries is not required when another payer, including Medicare, is the primary payer.

4. Q: If the client has a Washington State Medicaid card isn't s/he eligible for services?

   A: No, clients are issued a card for their lifetime. Eligibility must be verified every time services are provided to assure coverage and benefits under Washington State Medicaid.

5. Q: How long will it take for an approval from Washington State Medicaid?

A: Washington State Medicaid has 15 days from the day the request is submitted to Qualis Health to complete and send the provider a final written determination per WAC 182-501-0165. Completeness of clinical information to Qualis Health supports timely reviews and decisions.

6. Q: How do I get authorization for a surgery performed urgently or as an emergency?

A: Providers are allowed five (5) business days to submit a valid retrospective authorization request through Qualis Health for an urgent or emergency surgical procedure. Submit your request just as you would a request for a scheduled procedure. Qualis Health will review the request for the medical necessity of performing the procedure urgently or as an emergency.

7. Q: Is the reference number from Qualis Health an authorization number?

A: No, this number is a Qualis Health case identification number only. Receiving this number from Qualis Health does not equate to an Agency approval for payment. This number does not mean the procedure will be authorized for payment by the Health Care Authority's (HCA) Medicaid program. **Providers must wait until a number is assigned in ProviderOne with a final status of "approved" or until they receive the Agency's written determination.**

8. Q: Is any type of authorization required for surgeries performed urgently or as an emergency?

A: Yes, in these circumstances retrospective authorization is required.

9. Q: What is "ERSO"?

A: "ERSO" means Emergency Related Services Only and is the program formerly known as "Alien Emergency Medical". ERSO is a program for non-citizens who:

- Have a qualifying emergent medical condition;
- Would be eligible for Medicaid if he/she were a citizen; and
- Are ineligible for a full-scope Medicaid program due to immigrant status.

Clients who are receiving treatment for cancer and end-stage renal disease may require surgery to treat this condition, or a directly- related condition. If surgery is required, submit a request to the Washington State Medicaid following usual authorization procedures.

10. Q: How do I request authorization for additional surgeons (assistant surgeons, co-surgeons, and surgical teams)?

A: Please submit the information on your request to Qualis Health using the comments box on an electronically submitted request or on the paper form you fax Qualis Health. You will need the modifier, the billing NPI(s) of the additional surgeon(s), and the clinical justification.

11. Q: What process does Qualis Health follow for denied requests?

A: The physician or practitioner may request a re-review of a denial at http://www.qualishealth.org/healthcare-professionals/washington-medicaid/provider-resources.

The requestor will need to:

1. Indicate the Qualis Health reference number (starting with 913…) for which the review is being requested.
2. Fax the form and last three months (if available) of clinical notes and related imaging reports to Qualis Health at (888) 213-7516.

Upon receipt of a request for re-review, Qualis Health staff will review documentation to determine if the request can be approved. If not, the request will be forwarded to a physician reviewer who will review the medical information to determine if medical necessity criteria for the procedure are met. More information about the reconsideration process is available at: http://www.qualishealth.org/healthcare-professionals/washington-medicaid/provider-resources.

If Qualis Health ultimately recommends the authorization be denied and Washington State Medicaid agrees, the client has the right to appeal.

12. Q: How does the client appeal a decision by Washington State Medicaid?

A: In the case of a denial, the client will receive a letter from Washington State Medicaid including information about how to appeal through the Administrative Hearings Office. In addition, a client may call the Medicaid Customer Service Center phone line (**1-800-562-3022**) and state the desire to appeal a decision. Phone line hours for clients are from 7:30 a.m. to 5:00 p.m. Our phone staff will direct the client to the Administrative Hearings Office.

13. Q: Can I extend the dates of service for the authorization?

A: Washington State Medicaid's standard practice is to approve a request for a three-month time span, then extend it up to three additional months if necessary. Contact Medicaid authorization staff at 1-800-562-3022, ext. 52018 between the hours of 1:00 pm and 4:30 pm to request a date span extension for an approved surgery prior authorization request.

An extension beyond six months will require a new prior authorization as the patient's medical condition may have changed.

14. Q: What is the time limit for retroactive authorizations for services other than urgent requests ordered on the same day?

A: HCA considers retroactive authorization when the following applies:

1. Client's eligibility is approved after the date of service, but retroactive to a date(s) that includes the date the surgical procedure was performed; or

2. The primary payer does not pay for the service and Washington State Medicaid is identified as the primary payer.

There is no time limit for retroactive authorizations under circumstances 1 and 2 above.

15. Q: How do I get copies of billing instructions and other notifications from Washington State Medicaid?

A: Subscribe to a distribution list for medical providers who work with the Washington State Medicaid program. Email distribution is a major source of information for Washington State Medicaid providers, including updates on rate changes, billing tips, program details, and other issues of provider concern.

The distribution list includes specific provider categories, targeting the information to particular interest areas. To subscribe, follow this link to Washington State's Medicaid's Listserv sign up page. https://fortress.wa.gov/dshs/hrsalistsrvsignup/